SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Filing at a Glance

Company: AIG Life Insurance Company

Product Name: Group Term Life/ Disability	SERFF Tr Num: AMGN-125940373	State: ArkansasLH
TOI: L04G Group Life - Term	SERFF Status: Closed	State Tr Num: 41103
Sub-TOI: L04G.500 Other	Co Tr Num: G-APP-40090	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Maggie Sheehan, Bernadette Pham	Disposition Date: 01/20/2009
	Date Submitted: 12/11/2008	Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Part II Medical Application	Status of Filing in Domicile: Pending
Project Number: G-APP-40090	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association
Filing Status Changed: 01/20/2009	
State Status Changed: 01/20/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We wish to submit the above referenced filing for your review and approval.

The individual application, G-APP-40090 will be used by underwriting to obtain additional information from medical providers related to medical histories/conditions and provide a current examination of the proposed insured.

This individual application is a new form and is not intended to replace any existing forms previously filed and approved.

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed.

This application will be implemented for use upon approval by your Department.

Your review of this filing is appreciated. Please contact me if you have any questions.

Company and Contact

Filing Contact Information

Maggie Sheehan, Analyst
3600 Route 66
Neptune, NJ 07754

maggie_sheehan@aigag.com
(732) 922-7688 [Phone]
(732) 922-5593[FAX]

Filing Company Information

AIG Life Insurance Company
600 King Street
Wilmington, DE 19801
(713) 831-3508 ext. [Phone]

CoCode: 66842
Group Code: 12
Group Name:
FEIN Number: 25-1118523

State of Domicile: Delaware
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AIG Life Insurance Company	$50.00	12/11/2008	24474161

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/20/2009	01/20/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	12/17/2008	12/17/2008	Bernadette Pham	01/15/2009	01/15/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Medical APP	Form	Bernadette Pham	01/16/2009	01/16/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection Letter of 12/17/2008	Note To Filer	Linda Bird	01/15/2009	01/15/2009

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Disposition

Disposition Date: 01/20/2009
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Form *(revised)*	Medical APP		Yes
Form	Part II Medical APP		Yes

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/17/2008
Submitted Date	12/17/2008
Respond By Date	

Dear Maggie Sheehan,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application (Supporting Document)

Comment: Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/15/2009
Submitted Date	01/15/2009

Dear Linda Bird,

Comments:

Response 1

Comments: Dear Linda Bird,

In your response to your letter dated 12/17/2008 to Maggie Sheehan, I am in the process of reviewing the comments regarding this filing in her absence. However, I would like to request an extension until January 26, 2009 in order to complete this review, make any necessary changes to the form, and respond accordingly.

Your consideration of my request is greatly appreciated. Please let me know of your decision.

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
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Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Thank you.
Bernadette Pham
Analyst, Compliance

Related Objection 1

Applies To:

- Application (Supporting Document)

Comment:

Ark. Code Ann. 23-66-503(a) requires a statement in an application substantially the same as that included in the statute.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Bernadette Pham, Maggie Sheehan

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Amendment Letter

Amendment Date:

Submitted Date: 01/16/2009

Comments:

Dear Linda Bird,

I have reviewed your comments of 12/17/2008 regarding the inclusion of the "Fraud Statement".

My findings are that the submitted medical application will be attached to and will become part of the base application. The base application already contains the "Fraud Statement". Thus, this requested/submitted medical application does not need the "Fraud Statement".

Please advise should need additional information.

In addition, please note that I have attached an updated medical application with the following updates:
- updated the Company logo
- removed the line regarding a subsidiary of AIG
- removed the words "Part II" from the medical application

Your consideration is appreciated.

Thank you.
Bernadette Pham
Analyst, Compliance

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
G-APP-40090	Application/Enrollment Form	Medical APP	Revised		G-APP-40090	G-APP-40090	52	Final Medical App.pdf

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Note To Filer

Created By:

Linda Bird on 01/15/2009 11:21 AM

Subject:

Objection Letter of 12/17/2008

Comments:

We will be happy to allow an extension until January 26, 2009 on this filing.

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Form Schedule

Lead Form Number: G-APP-40090

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	G-APP-40090	Application/ Enrollment Form	Medical APP	Revised	Replaced Form #: G-APP-40090 Previous Filing #: G-APP-40090	52	Final Medical App.pdf

American General
Life Companies

[ ]

[☐ AIG Life Insurance Company]*
[☐ American International Life Assurance Company of New York]*
[☐ American General Assurance Company]*
[☐ The United States Life Insurance Company in the City of New York]*
(Herein called the Company)

Policy No._____

The insurance company checked above (Company) is responsible for the obligation and payment of benefits under any policy that it may issue.

STATEMENTS MADE TO THE MEDICAL EXAMINER

1 A. Full Name of Proposed Insured	B. Date of Birth	C. Occupation	Employer

2. Have you ever applied for or received disability benefits from any source? Yes☐ No☐ (if yes, give details)	3. Has any application for or reinstatement of Life, Accident, Health or Disability Insurance ever been declined, postponed, rated or in any way modified? Yes☐ No☐ (if yes, give details, date and company)

4. Have you ever been diagnosed with or treated for drug or alcohol abuse or advised to reduce alcohol use? Yes No (if yes, give details)

5. HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH	**Yes or No**	IF YES, GIVE DETAILS Description Dates Duration Doctor's names and addresses
A. Seizure disorder, paralysis, dizziness, fainting spells, mental/nervous disorder, stroke/cerebrovascular accident, aneurysm, transient ischemic attack, blood clot or disorder of the brain or spinal cord or any other neurological disorder?		
B. High blood pressure, high cholesterol, chest pain, Shortness of breath, irregular heartbeat, heart murmur, heart disease, heart attack, or other disorder of the heart, blood vessels or veins?		
C. Asthma, bronchitis, emphysema, pleurisy, hemorrhage, tuberculosis, sleep apnea or other breathing or respiratory disease or disorder?		
D. Diabetes, colitis, hepatitis, or any disease or disorder of the esophagus, pancreas, stomach, gall bladder, liver or digestive system?		
E. Any disease or disorder of the kidneys, bladder, prostate, reproductive organs or sugar or protein in the urine?		
F. Cancer, tumors, masses, cysts or other such abnormalities?		
G. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or other immune disorder?		
H. Disease or disorder of the thyroid, blood, glands, skin or lymphatic system?		
I. Rheumatic fever, arthritis, osteomyelitis, disease or disorder of the bones, joints, spine or muscles or connective tissue disease, chronic pain, or chronic fatigue?		
J. Impairment of vision or hearing or disease or disorder of the eyes or ears?		
K. Treatment or observation in any hospital or institution within the past 10 years or been advised to have diagnostic tests or treatment that was not completed?		
L. Consultations with any physicians or practitioners other than stated above within the past 10 years?		
M. X-rays or electrocardiograms within the past 10 years? When, why, by whom with what results?		

American General
Life Companies

[ ]

6. Family Record	Age if living	Age at Death	Cause of Death
Father			
Mother			

7. A
Height……..ft……in

B Weight……lbs.

C. Any changes in weight in excess of 10 lbs. in the past 12 months? Yes☐ No☐

Loss……..lbs. Gain……..lbs.

Give reason for change:

8. Have you used tobacco in any form during the past 12 months? Yes☐ No☐

All of the above answers are full, complete and true; are a continuation of, and form a part of the application for insurance on my life to The Company.

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau**,** to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Signed at…….this…….day of……20……..
(City and State of County)

Witness……..…….
Medical Examiner **Signature of Proposed Insured**

Please print name of proposed insured_____

DO NOT DETACH – MAIL ENTIRE FORM DIRECTLY TO
The Company at the administrative address of [3600 Route 66, Medical Underwriting , P.O. Box 1588 Neptune, NJ 07754-1588]

Name of Group/Policyholder_____

American General
Life Companies

[ ]

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. Use for group insurance applications only.
2. When an Examination is begun, the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid declination.
3. An Examiner is not permitted to examine his own patients or relatives or cases for an agent who is a relative.
4. Any erasures or alterations in the statement made by the proposed insured must be signed by the applicant.
5. Any erasures or alterations in your report should be signed by you.

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

Name of Proposed Insured:…….....

9. A. How long have you known the proposed insured? …….... B. Are you related? .....

10. A. Height……..ft…….in. C. Did you Weigh applicant?..... D. Girth: Chest expiration……..inches
B. Weight……lbs. Measure applicant?..... Chest full inspiration……..inches
Abdomen at umbilicus……inches

11. Name and address of applicant's usual medical attendant or primary care physician?_____
_____

12. Does inquiry or examination reveal any past or present disease of the brain, chest, digestive, genitourinary, cardiovascular, renal, glandular or nervous system?_____
_____

13. A. Is applicant's appearance unhealthy?_____
B. Does applicant appear older than given age?_____
Why?_____
_____
_____
C Is there any impairment of sight or hearing?_____
_____
_____

Blood pressure (record all readings). If blood pressure exceeds 140/90 repeat reading at end of examination*.

Systolic BP	1st Reading	2nd Reading	3rd Reading	*Repeat Reading	
Diastolic 5th phase BP					
Pulse Rate					
Irregularities per Min.					

REPORT BY EXAMINING MEDICAL DOCTOR

Instructions to doctor:
To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1.) Heart

a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? Yes☐ No☐
b. Is heart enlarged? Yes☐ No☐
(if yes describe)_____
c. Is murmur present? Yes☐ No☐
(if yes, complete d)_____
d. Before exercise, murmur is:
☐ Constant Transmitted to where?_____
☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere
☐ Systolic (give details)_____
☐ Diastolic Murmur grade: (please circle) 1/6 2/6 3/6 4/6 5/6 6/6
After valsalva, murmur is:
☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression _____

I certify that I have made this examination in private at
_____
No. and Street City and State Zip code

this_____day of _____, 20_____at _____O'clock____m.
Examiner's Phone #_____ Examiner's Name _____
Examiner's Signature_____

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
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Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 12/10/2008

Comments:

Attachments:

AR LH214AR_112805.pdf

Readability Certification _KC_.pdf

Review Status:

Satisfied -Name: Application 12/10/2008

Comments:

Attachment:

Final Part II App.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The United States Life Insurance Company in the City of New York
AIG Life Insurance Company
American General Assurance Company

Form Number(s): G-APP-40090

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Keith Coleman
Name

Compliance Officer
Title

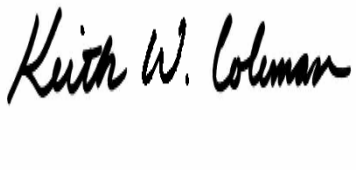
December 10, 2008
Date

.READABILITY CERTIFICATION

I, Keith Coleman, Compliance Officer, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Score is as follows:

Part II Medical Application	G-APP-40090	52.2



Date: 12/10/2008

Keith Coleman
Compliance Officer

[AIG AMERICAN GENERAL]

[☐ AIG Life Insurance Company]*
[☐ American International Life Assurance Company of New York]*
[☐ American General Assurance Company]*
[☐ The United States Life Insurance Company in the City of New York]*
(Herein called the Company)

Policy No._____

A subsidiary of [American International Group, Inc. (AIG)]

The insurance company checked above (Company) is responsible for the obligation and payment of benefits under any policy that it may issue.

PART II STATEMENTS MADE TO THE MEDICAL EXAMINER

1 A. Full Name of Proposed Insured	B. Date of Birth	C. Occupation	Employer

2. Have you ever applied for or received disability benefits from any source? Yes☐ No☐ (if yes, give details)	3. Has any application for or reinstatement of Life, Accident, Health or Disability Insurance ever been declined, postponed, rated or in any way modified? Yes☐ No☐ (if yes, give details, date and company)

4. Have you ever been diagnosed with or treated for drug or alcohol abuse or advised to reduce alcohol use? Yes No (if yes, give details)

5. HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH	**Yes or No**	IF YES, GIVE DETAILS Description Dates Duration Doctor's names and addresses
A. Seizure disorder, paralysis, dizziness, fainting spells, mental/nervous disorder, stroke/cerebrovascular accident, aneurysm, transient ischemic attack, blood clot or disorder of the brain or spinal cord or any other neurological disorder?		
B. High blood pressure, high cholesterol, chest pain, Shortness of breath, irregular heartbeat, heart murmur, heart disease, heart attack, or other disorder of the heart, blood vessels or veins?		
C. Asthma, bronchitis, emphysema, pleurisy, hemorrhage, tuberculosis, sleep apnea or other breathing or respiratory disease or disorder?		
D. Diabetes, colitis, hepatitis, or any disease or disorder of the esophagus, pancreas, stomach, gall bladder, liver or digestive system?		
E. Any disease or disorder of the kidneys, bladder, prostate, reproductive organs or sugar or protein in the urine?		
F. Cancer, tumors, masses, cysts or other such abnormalities?		
G. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or other immune disorder?		
H. Disease or disorder of the thyroid, blood, glands, skin or lymphatic system?		
I. Rheumatic fever, arthritis, osteomyelitis, disease or disorder of the bones, joints, spine or muscles or connective tissue disease, chronic pain, or chronic fatigue?		
J. Impairment of vision or hearing or disease or disorder of the eyes or ears?		
K. Treatment or observation in any hospital or institution within the past 10 years or been advised to have diagnostic tests or treatment that was not completed?		
L. Consultations with any physicians or practitioners other than stated above within the past 10 years?		
M. X-rays or electrocardiograms within the past 10 years? When, why, by whom with what results?		

[AIG AMERICAN GENERAL]

6. Family Record	Age if living	Age at Death	Cause of Death
Father			
Mother			

7. A
Height……..ft……in

B Weight……lbs.

C. Any changes in weight in excess of 10 lbs. in the past 12 months? Yes☐ No☐

Loss……..lbs. Gain……..lbs.

Give reason for change:

8. Have you used tobacco in any form during the past 12 months? Yes☐ No☐

All of the above answers are full, complete and true; are a continuation of, and form a part of the application for insurance on my life to The Company.

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau**,** to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Signed at…….this…….day of……20……..
(City and State of County)

Witness……..…….
Medical Examiner **Signature of Proposed Insured**

Please print name of proposed insured_____

DO NOT DETACH – MAIL ENTIRE FORM DIRECTLY TO
The Company at the administrative address of [3600 Route 66, Medical Underwriting , P.O. Box 1588 Neptune, NJ 07754-1588]

Name of Group/Policyholder_____

[AIG AMERICAN GENERAL]

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. Use for group insurance applications only.
2. When an Examination is begun, the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid declination.
3. An Examiner is not permitted to examine his own patients or relatives or cases for an agent who is a relative.
4. Any erasures or alterations in the statement made by the proposed insured must be signed by the applicant.
5. Any erasures or alterations in your report should be signed by you.

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

Name of Proposed Insured:…….....

9. A. How long have you known the proposed insured? …….... B. Are you related? .....

10. A. Height……..ft…….in. C. Did you Weigh applicant?..... D. Girth: Chest expiration……..inches
B. Weight……lbs. Measure applicant?..... Chest full inspiration……..inches
Abdomen at umbilicus……inches

11. Name and address of applicant's usual medical attendant or primary care physician?_____
_____

12. Does inquiry or examination reveal any past or present disease of the brain, chest, digestive, genitourinary, cardiovascular, renal, glandular or nervous
system?_____
_____

13. A. Is applicant's appearance unhealthy?_____
B. Does applicant appear older than given age?_____
Why?_____
_____
_____
C Is there any impairment of sight or hearing?_____
_____
_____

Blood pressure (record all readings). If blood pressure exceeds 140/90 repeat reading at end of examination*.

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th phase BP				
Pulse Rate				
Irregularities per Min.				

REPORT BY EXAMINING MEDICAL DOCTOR

Instructions to doctor:
To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1.) Heart

a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? Yes☐ No☐
b. Is heart enlarged? Yes☐ No☐
(if yes describe)_____
c. Is murmur present? Yes☐ No☐
(if yes, complete d)_____
d. Before exercise, murmur is:
☐ Constant Transmitted to where?_____
☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere
☐ Systolic (give details)_____
☐ Diastolic Murmur grade: (please circle) 1/6 2/6 3/6 4/6 5/6 6/6
After valsalva, murmur is:
☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression _____

I certify that I have made this examination in private at
_____
No. and Street City and State Zip code

this_____day of _____, 20_____at _____O'clock____m.
Examiner's Phone #_____ Examiner's Name _____

Examiner's Signature_____

SERFF Tracking Number:	*AMGN-125940373*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*41103*
Company Tracking Number:	*G-APP-40090*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Term Life/ Disability*		
Project Name/Number:	*Part II Medical Application/G-APP-40090*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Part II Medical APP	12/11/2008	Final Part II App.pdf

[AIG AMERICAN GENERAL]

[☐ AIG Life Insurance Company]*
[☐ American International Life Assurance Company of New York]*
[☐ American General Assurance Company]*
[☐ The United States Life Insurance Company in the City of New York]*
(Herein called the Company)

Policy No._____

A subsidiary of [American International Group, Inc. (AIG)]

The insurance company checked above (Company) is responsible for the obligation and payment of benefits under any policy that it may issue.

PART II STATEMENTS MADE TO THE MEDICAL EXAMINER

1 A. Full Name of Proposed Insured	B. Date of Birth	C. Occupation	Employer

2. Have you ever applied for or received disability benefits from any source? Yes☐ No☐ (if yes, give details)	3. Has any application for or reinstatement of Life, Accident, Health or Disability Insurance ever been declined, postponed, rated or in any way modified? Yes☐ No☐ (if yes, give details, date and company)

4. Have you ever been diagnosed with or treated for drug or alcohol abuse or advised to reduce alcohol use? Yes No (if yes, give details)

5. HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH	**Yes or No**	IF YES, GIVE DETAILS Description Dates Duration Doctor's names and addresses
A. Seizure disorder, paralysis, dizziness, fainting spells, mental/nervous disorder, stroke/cerebrovascular accident, aneurysm, transient ischemic attack, blood clot or disorder of the brain or spinal cord or any other neurological disorder?		
B. High blood pressure, high cholesterol, chest pain, Shortness of breath, irregular heartbeat, heart murmur, heart disease, heart attack, or other disorder of the heart, blood vessels or veins?		
C. Asthma, bronchitis, emphysema, pleurisy, hemorrhage, tuberculosis, sleep apnea or other breathing or respiratory disease or disorder?		
D. Diabetes, colitis, hepatitis, or any disease or disorder of the esophagus, pancreas, stomach, gall bladder, liver or digestive system?		
E. Any disease or disorder of the kidneys, bladder, prostate, reproductive organs or sugar or protein in the urine?		
F. Cancer, tumors, masses, cysts or other such abnormalities?		
G. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or other immune disorder?		
H. Disease or disorder of the thyroid, blood, glands, skin or lymphatic system?		
I. Rheumatic fever, arthritis, osteomyelitis, disease or disorder of the bones, joints, spine or muscles or connective tissue disease, chronic pain, or chronic fatigue?		
J. Impairment of vision or hearing or disease or disorder of the eyes or ears?		
K. Treatment or observation in any hospital or institution within the past 10 years or been advised to have diagnostic tests or treatment that was not completed?		
L. Consultations with any physicians or practitioners other than stated above within the past 10 years?		
M. X-rays or electrocardiograms within the past 10 years? When, why, by whom with what results?		

[AIG AMERICAN GENERAL]

6. Family Record	Age if living	Age at Death	Cause of Death
Father			
Mother			

7. A
Height……..ft……in

B Weight……lbs.

C. Any changes in weight in excess of 10 lbs. in the past 12 months? Yes☐ No☐

Loss……..lbs. Gain……..lbs.

Give reason for change:

8. Have you used tobacco in any form during the past 12 months? Yes☐ No☐

All of the above answers are full, complete and true; are a continuation of, and form a part of the application for insurance on my life to The Company.

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau**,** to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Signed at…….this…….day of……20……..
(City and State of County)

Witness……..…….
Medical Examiner **Signature of Proposed Insured**

Please print name of proposed insured_____

DO NOT DETACH – MAIL ENTIRE FORM DIRECTLY TO
The Company at the administrative address of [3600 Route 66, Medical Underwriting , P.O. Box 1588 Neptune, NJ 07754-1588]

Name of Group/Policyholder_____

[AIG AMERICAN GENERAL]

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. Use for group insurance applications only.
2. When an Examination is begun, the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid declination.
3. An Examiner is not permitted to examine his own patients or relatives or cases for an agent who is a relative.
4. Any erasures or alterations in the statement made by the proposed insured must be signed by the applicant.
5. Any erasures or alterations in your report should be signed by you.

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

Name of Proposed Insured:…….....

9. A. How long have you known the proposed insured? …….... B. Are you related? .....

10. A. Height……..ft…….in. C. Did you Weigh applicant?..... D. Girth: Chest expiration……..inches
B. Weight……lbs. Measure applicant?..... Chest full inspiration……..inches
Abdomen at umbilicus……inches

11. Name and address of applicant's usual medical attendant or primary care physician?_____
_____

12. Does inquiry or examination reveal any past or present disease of the brain, chest, digestive, genitourinary, cardiovascular, renal, glandular or nervous
system?_____
_____

13. A. Is applicant's appearance unhealthy?_____
B. Does applicant appear older than given age?_____
Why?_____
_____
_____
C Is there any impairment of sight or hearing?_____
_____
_____

Blood pressure (record all readings). If blood pressure exceeds 140/90 repeat reading at end of examination*.

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th phase BP				
Pulse Rate				
Irregularities per Min.				

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Examiner's Phone #_____ Examiner's Name _____

Examiner's Signature_____